BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

THE RELATION OF ENVIRONMENTAL FACTORS TO FAILURE IN TREATMENT

A Study of Twenty-five Cases of Psychoneurotic Patients Discharged from the Mental Hygiene Clinic as Unimproved.

A Thesis

Submitted by

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(A.B., Mount Holyoke College, 1943)

In Partial Fulfillment of Requirements for

the Degree of Master of Science in Social Service

1948

CHAPTER I

INTRODUCTION AND METHODOLOGY

Purpose of Study

The purpose of this study is to estimate qualitatively how factors in the social developmental history and present social setting of a patient relate to his failure to improve while in treatment for a psychoneurotic disorder at the Veterans Administration Mental Hygiene Clinic. The writer wishes to see if there are reappearing environmental factors in the backgrounds of these psychoneurotic patients that go into building up a certain type of personality that is more difficult to treat. In order to arrive at the conclusions, the following questions will be formed:

1. Are there certain personality types that resist treatment?

2. Are there reappearing factors in these patients' backgrounds that are responsible for this?

3. Does this suggest any ways that these failures in treatment may be overcome?

Scope and Method of Procedure

The twenty-five cases used for this thesis were chosen from a group of two-hundred and fifty. This group represented patients who had come to the Veterans Administration Mental Hygiene Clinic during the spring of 1947. This particular group was chosen because they had been known to the clinic long enough ago to have a psychiatric survey and a final disposition and also would fall under the newer methods of assignment of cases. Each of the twenty-five cases chosen from this group was marked "unimproved". It was also necessary to pick cases that had enough of the patient's background to give suitable evidence. The writer tried to use as many cases with anamneses (see appendix) as possible. However, many had sufficient information in the psychiatric interviews.

All patients were Veterans of WWII. They each had had several contacts with either a psychiatrist, a social worker, or a clinical psychologist in order to get psychotherapeutic assistance.

A case is closed "unimproved" for various reasons. If a patient fails to keep his appointment for two consecutive weeks, the case is closed. If the patient has shown no improvement up until the time he ceased keeping the appointments, he is discharged as "unimproved". On the other hand, the patient may come to the therapist and tell him

that he feels that he has not been getting anything out of treatment and wishes to discontinue coming. Sometimes it is necessary for a patient to be discharged because of VA technicalities. The writer has not used any of these cases in this last group, as they are not related to the subject.

It is hard to set up any definite criteria for "unimprovement" and "improvement". The unimproved patient does not show any greater adjustment as a result of treatment. He has not moved any closer to the immediate goal set up in therapy for him. The criteria for "unimprovement" seem to differ slightly in the minds of each individual therapist. In one of the cases used for this thesis the patient seemed improved to the therapist, but since the patient insisted that he had not benefitted by treatment, he was discharged as "unimproved". In other cases that the writer has read, a patient has been discharged as "improved" because he seems to show some improvement to the therapist though not to himself. The reasons why these cases were discharged as "unimproved" will be explored more fully in Chapter III of this paper, but it must be remembered that failure in treatment is surrounded by a large personal factor and cannot be closely defined.

For each of the twenty-five cases used, an abstract has been prepared. In each of these abstracts the writer has tried to bring out the following information:

1. How patient came to the clinic and why.

2. Diagnosis and prognosis at intake.

3. Pertinent patterns in social background as well as basic background information.

4. History of war service with emphasis on man's adjustment and stress.

5. Personality make-up.

6. Relation to treatment and therapist.

7. Apparent reason for failure of treatment.

8. Connection of failure of treatment with social background and personality picture.

The History and Organization of the Mental Hygiene Clinic

The Boston Veterans Administration Mental Hygiene Clinic was opened March 18, 1946 at the West Roxbury Veterans Hospital. At that time the staff consisted of three full-time psychiatrists, four part-time psychiatric consultants, three full-time psychologists and five full-time psychiatric social workers.[1] At the present time over 2400 men have been given psychiatric aid at the clinic. The staff consists of over thirty psychiatrists, ten psychologists, and seventeen psychiatric social workers. It is now located at 175 Washington Street.

The patients coming to the clinic are veterans who find that they cannot adjust to normal living because of their psychoneurotic symptoms. They have come to the point where they must ask for help. Many have put this off for as long as two or three years. There are many who actually have insight into their disorder and realize that it is not organically founded. However, there are a great many who cannot picture anything that does not have an organic basis.

The present method of procedure in intake and treatment is as follows: A patient comes to the clinic. He is usually referred from some other VA facility because they have found

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1 Morris Adler and Edward Burchard, "Survey of the First Three Months of a Veterans Administration Mental Hygiene Clinic," p. 1.

that he is asking for psychiatric help and is receiving a pension for a nervous disability. At intake he is seen by a psychiatric social worker and a psychiatrist. His eligibility is determined. At present it is necessary to have a pension for nervousness adjudicated. A brief survey of his symptoms and background is taken. What is most important is to get the patient's real reason for coming to the clinic. The psychiatrist gives a diagnosis and recommendation for treatment and his evaluation of the prognosis of the case. The patient is also given a brief indoctrination as to the function of the clinic. He is given an appointment for treatment. The clinic offers various types of treatment which seem to fall under three catagories, case work, psychotherapy, and group therapy. A patient may be assigned to one or a combination of any of these three therapies. Sometimes a man may be receiving individual therapy from a psychiatrist, may be seeing a social worker for an anamnesis, and may also be taking a Rorschach with a psychologist.

The clinic has gone through a series of changes in its two years of existence. The aim has always been to keep it as up to date as possible. For this end a series of lectures is given by visiting psychiatrists, psychologists, and social workers which the whole staff attend. Cases are also presented by individual workers before the entire staff for discussion. Research projects are carried on by all of the mem-

bers of the staff.

There has been a great deal of discussion and change as to the role in therapy that the various workers should take. At present, the psychiatrists carry on therapy on an insight level. The psychiatric social workers are assigned cases that need supportive treatment with little insight. The passive-dependent seems to benefit to some extent from supportive therapy. The Social Service Department is also responsible for anamneses.

CHAPTER II

SOME GENERAL CHARACTERISTICS OF THE GROUP

Before presenting the evidence of this thesis it is necessary to define the general terms and characteristics peculiar to the group of twenty-five. The terms psychoneurosis and war neurosis have been used so loosely that it is necessary to redefine them.

Psychoneurotic is applied to that large group of individuals that fall between those that function normally in all phases of life and those that are completely withdrawn from reality, such as those falling in the psychotic group. It covers a broad field which encompasses those people who complain that "nervousness" and irritability keep them from functioning as they should to those which seem to have definite symptoms similar to ones of physical basis. All of these give evidence of emotional stress and show no physical basis. In a psychoneurosis there is "only a partial personality altering and environmental contacts remain relatively real and undisturbed".[1] In a psychotic there is almost a complete withdrawal from environment. A psychoneurotic still possesses reason in a broad sense although it may be distorted.

The men treated at the clinic are supposedly suffering from "War Neurosis" since every case treated must show a

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1 Arthur P. Noyes, Modern Clinical Psychiatry, p. 332.

service connection. There does not seem to be any large differentiation between a "War Neurosis" and any other according to most authors. "War merely offers new and more frequent opportunities for development of neurosis."[2] Kardiner, however, gives a series of personality features that seem to be common in those men suffering from "War Neurosis". "a. A highly characteristic dream life (fighting, violence), b. Inhibitions to social and economic usefulness, c. acoustic hypersensitivity, d. irritability, e. outbursts of temper."[3] Generally speaking, the symptoms of the men seen at the clinic seem to have developed during the war experience, and a great many of them manifest these features that Kardiner outlines.

Brief psychotherapy has proven most useful in working with these patients during the war, and it has been of great value in the clinic. For evidences of its success, the writer refers the reader to a study by Mrs. Nancy Park on veterans improved at the clinic.[4] This is a quantitative study of one-hundred cases which showed improvement. The writer will attempt to compare some of the more significant factors in Mrs. Park's thesis with this study. Psychotherapy has proven unsuccessful many times even after a great many contacts. Aside from the possible failure on the part of the therapist, it seems that there may be specific personality factors which

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2 A. Kardiner, War Medicine, 1:219, 1941.
3 Ibid.
4 Nancy Park, "A Descriptive Study of Veterans Improved by Psychiatric Treatment."

are harder to treat than others, or specific types of psychoneuroses that prove more difficult. Since it seems that these basically arise from the constitutional and early development forces on the individual, it seems plausible that we should seek out factors in the patient's background that make for this lack of success in treatment.

Grinker and Spiegel have outlined some general criteria for prognosis which seemed to be evident in the cases they treated during the war in which they include:

1. Patient's background, assets and capacities, his predisposing liabilities.
2. Degree to which exhaustion contributes to the breakdown.
3. Previous recent traumata.
4. Severity of precipitating traumata.
5. Quantity of anxiety.
6. Strength of ego.
7. Capacity for psychological understanding.
8. Degree of repressed hostility.
9. Type of clinical syndrome.
10. Time element.[5]

A breakdown of the diagnoses of the twenty-five cases used appears in Table No. 1. The writer has compared this with the scatter of diagnoses in the cases used in Mrs. Park's

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5 Roy R. Grinker and John P. Spiegel, War Neuroses, p. 71.

study of successful treatment at the Clinic.[6] It should be noted that nine of the twenty-five cases chosen for this study were Character-Behavior Disorders. Five were diagnosed as Anxiety Reaction and five as Neurotic Depressive reaction. Although this is not a statistical study, it is interesting to note the difference in scatter. Over half of those cases that were successful in treatment were Anxiety Reaction patients. It has also been found that there are many more patients with the diagnosis of Anxiety Reaction at the clinic than any other. This would seem to indicate that Anxiety Reaction patients are not as hard to treat as Character-Behavior Disorders, but one cannot come to any statistical conclusions with such a small number of cases. The writer has enclosed in the appendix a copy of the Mental Hygiene Clinic's divisions of psychoneurotic illness which may be of assistance in classifying these various diagnoses.

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6 Park, op. cit., p. 15.

TABLE I

DIAGNOSES APPEARING IN SUCCESSFUL AND UNSUCCESSFUL STUDIES

Diagnosis	No. Unsuccessful	Per cent	No. Successful[a]	Per cent
1. Neurotic Depressive Reaction	5	20.0	10	10.0
2. Anxiety Reaction	5	20.0	52	52.0
3. Somatization Reaction	4	16.0	9	9.0
4. Dissociative Reaction	1	4.0	0	0.0
5. Obsessive Compulsive	1	4.0	4	4.0
6. Conversion Reaction	0	0.0	7	7.0
7. Hypochondriacal Reaction	0	0.0	1	1.0
8. Schizoid Reaction	0	0.0	1	1.0
9. Character Behavior Reaction	9	36.0	14	14.0
10. Acute Situational Maladjustment	0	0.0	1	1.0
11. Convulsive Disorder	0	0.0	1	1.0
Total	25	100.0	100	100.0

a Park, op. cit., p. 15.

"Degree of repressed hostility", No. 8 in Grinker and Spiegel's list of Criteria for Prognosis, was a general characteristic that was quite in evidence in this group.[8] In all but three of these cases there was a great deal of agressiveness, hostility and resistance. It was so in evidence that practically every therapist remarked on it as a reason for failure in the case. It seems to be one of the greatest difficulties encountered in the treatment of those suffering from war neurosis. The writer quotes Grinker and Spiegel:

> "The sullen antagonistic disrespectful patient with large quantities of hostility is often a difficult problem. He may have no insight into his illness and his negative attitude toward the therapist blocks his treatment. Those that are fearful of their hostilities, or feel guilty about them, offer better prognosis. Many seem unable to verbalize their aggression and repetitively liberate them into action. This group is the most difficult to treat and from it we have the greatest number of failures. In many of these cases chronic symptoms develop early in their clinical course, which resemble those of the untreatable cases still suffering since the last war."[9]

Although not included in the criteria for prognosis of Grinker and Spiegel, age is also considered an important factor in treatability and therefore in failure of treatment. According to Alexander and French, "Advanced age is not an absolute contradiction, on the other hand, prognosis is better for the young who have a far greater opportunity for change and who, therefore, usually respond more readily to treatment."[10]

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8 Roy Grinker and John Spiegel, War Neurosis, p. 71.
9 Roy Grinker and John Spiegel, Men Against Stress, p. 326.
10 Franz Alexander and Thomas French, Psychoanalytic Therapy, p. 97.

TABLE II

AGE GROUPING FOR SUCCESSFUL AND UNSUCCESSFUL CASES

Age Group	Unsuccessful Cases		Successful Cases[a]	
	Number	Per cent	Number	Per cent
Under 20	0	0.0	2	2.0
20 - 24	9	36.0	25	25.0
25 - 29	9	36.0	35	35.0
30 - 34	5	20.0	18	18.0
35 and over	2	8.0	20	20.0
Total	25	100.0	100	100.0

This scatter certainly does not indicate that the cases used fall in an older age bracket than those cases that were successful in treatment.

There are probably many more general characteristics that could be brought out about this group of men, but since they will be discussed more specifically in the presentation of the evidence in the next two chapters, they will not be presented here. The aim of this study is to make a qualitative evaluation of the environmental factors evident in the failure of treatment, and it does not seem necessary to measure the group as a whole statistically, as the figures would not be valid because of the small number in the group.

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a Park, op. cit., p. 8.

In evaluating these twenty-five cases, the writer has focused on the patient's points of stress and his ability to measure up to situations. This can only be measured in how adeptly the patient has handled them and his achievement in them. The general points of possible stress in these veterans' lives seem to be the home situation, sibling relationship, educational achievement, service stress and relative adjustment, work level and adjustment, and marital adjustment. The major factors that present themselves in each case are represented in the tables in Chapters III and IV along with abstracts of some of these cases.

CHAPTER III

PRESENTATION AND ANALYSIS OF DATA

Introduction

These twenty-five cases seemed to group themselves according to the number of contacts with the clinic. Those patients who were just seen at the clinic a few times seemed to fail in treatment for much different reasons than did those that were seen a great many times. It is for this reason that the writer has divided these cases into four groups as designated in the table below.

TABLE III

GROUPING ACCORDING TO CONTACTS

Group No.	No. Contacts	Unimproved		Improved[a]	
		Cases	Per cent	Cases	Per cent
I	1 - 4	9	36.0	4	4.0
II	5 - 9	7	28.0	34	34.0
III	10 - 14	3	21.0	27	27.0
IV	15 and over	6	36.0	35	35.0
	Total	25	100.0	100	100.0

Each case in the four groups has been evaluated in some way by the therapist working with the patient or the intake worker, as to why the patient is showing so much resistance

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[a] Park, op. cit., p. 13.

to treatment or why the prognosis is poor. Tables have been prepared of the cases in each group showing the environmental stress and reasons for treatment failure. These will be included along with abstracts of some of the cases in each group, tables of the general characteristics of the group, and a discussion of the group.

TABLE IV

GENERAL CHARACTERISTICS OF GROUP I

No.	Diag-nosis	Age	Home Sit.	Ed. Level	Service Adj.	Stress	Marital	Work	Contacts
3	Neur. Dep.	25	Broken	12th G.	Poor	Max.	Married	W.	2
5	Som. Reac.	34		10th G.	Good	Max.	Married	W.	3
6	Anx. Reac.	23		9th G.	Fair	Max.	Married	W.	4
10	Char. Beh.	30		12th G.	Fair	Min.	Single	W.	4
12	Char. Beh.	38		?	Fair	Min.	Single	W.	1
15	Som. Reac.	24	Broken	9th G.	Fair	Min.	Married	W.	4
20	Anx. Reac.	30	Broken	9th G.	Good	Max.	Married	W.	1
23	Char. Beh.	23	Broken	12th G.	Good	Min.	Single	Unemp.	3
26	Som. Reac.	26		?	Poor	Med.	Married	W.	3

Group I

Group I consists of nine cases. These are all patients that were seen from only one to four times at the clinic. This represents the largest number of unsuccessful cases. In the study of successful cases,[1] the fewest number of patients were represented in this group. Of these nine, three were diagnosed as Character-Behavior disorders, three as Somatic Reaction, two as Anxiety Reaction, and one as a Neurotic Depressive Reaction. The ages ranged from twenty-three to thirty-eight. All had gone above ninth grade in school. None had gone to college. Four came from broken homes. Three were single, and the rest were married. All but two had made a fairly good service adjustment. All but one was working at the time of contact with the clinic.

Six of these ceased keeping appointments. The other three told the therapist that they did not wish any further treatment. Seven showed considerable resistance, hostility, and aggression toward the therapist while in treatment. Seven were ambivalent about treatment or did not desire it at all. This seems to be the main reason for the lack of success in the cases represented in Group I. The environmental factors will be explored after the presentation of the abstracts.

The following is an abstract of a case seen only four times. Three of these contacts were with a social worker for

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1 Park, op. cit.

an anamnesis and one was with a psychiatrist. This man came for treatment when the clinic was very crowded, and there was a waiting list for appointments with the psychiatrists. Therefore, one of the purposes for taking the anamnesis was to tide over the waiting period between intake and the first appointment with the psychiatrist. There was still quite a long period, however, when the patient had no contact with the clinic. (This is case No. 15 on the charts.)

This twenty-four-year-old patient was referred from the West Roxbury Hospital where he had been x-rayed for gastro-intestinal difficulty. His chief complaints were:

1. Daily diarrhea.
2. Intense irritability.
3. Restlessness.
4. Inability to work in closed places
5. Intermittent urticaria in warm weather.

The provisional diagnosis given at the clinic was Gastro-Intestinal, Psychogenic Reaction.

This patient's father had died when he was a few months old. He had one older sister. His mother remarried when the patient was seven. His step-father had a son by another marriage that was the same age as the patient and who came to live with them. The patient's mother died four years ago. He claims that he never had a close relationship with anyone in his family. He did all types of work after he left school in

the ninth grade and more or less "bummed" around the country. He finally got a job with the railroad, the same type of job his father had had before he died.

The patient was a private in the Army for three years with minimal stress. He developed hives and stomach cramps while in the service and was finally discharged for them. His hives disappeared soon after leaving the service but reappeared one year later.

He married before entering the service and has a five-year-old daughter. His wife is the first person he had ever established a strong relationship with. Now the patient shows explosive rages in his wife's presence which are in marked contrast to his customary behavior, which is characterized by an extreme degree of emotional control. He never used to permit himself any outward expression of hostility or anger. He is also very aggressive with his child.

The following is quoted from the summary in the anamnesis:

> "The patient has never been able to express any grief or affection. He seems to have an underlying character disorder with a schizoid personality but with many obsessive compulsive features. He is very anxious for psychiatric treatment and is sure that his symptoms are not organically based."

After waiting for some time for an appointment with the psychiatrist, during which time he called frequently to ask if there was any opening, he called the VFW to ask them to press for an appointment. There was finally a vacancy, and he had one appointment with the psychiatrist and never came back.

This man seems to have been rejected in various situations throughout his whole life. He was rejected first by his father, then his mother, and it seems likely that he interprets his wife's care of their five-year-old daughter as another rejection. He came to the clinic and was "rejected" again because there was no appointment time left. He showed his determination not to be rejected by his frequent calls to the clinic asking for an appointment. After finally getting an appointment, he ceased coming, perhaps out of fear of being "rejected" again. Besides this, there is the history of not being able to form emotional attachments which seems to have been stimulated by his background of rejections. He, therefore, was not able to get a very firm relationship with the therapist in one hour of therapy. Also this man was able to work and support his family although sick. This would perhaps make him less anxious for treatment than someone who was not able to work. This is one of four cases in this group that shows this pattern of rejection in childhood. The other cases are Numbers 3, 5, and 23. In each of these cases, the worker had difficulty in establishing a relationship with the patient. Since approximately half of this group shows this pattern, it seems to show that this may be one of the environmental factors that points to failure in treatment in this group.

This next abstract is Case Number 10 on the table. This

patient also had four contacts with the clinic. Three were for anamnesis and one was in group therapy. The reason for failure in this case seems to have been a poor recommendation for type of treatment in intake in the assignment of this patient who had never been able to associate with men with a normal degree of masculinity to a group that threatened him because of their ego strength.

This is a thirty-year-old, single, white, Protestant veteran, who was referred from the OPD because he complained of headaches, pains in his stomach, and nervousness. His provisional diagnosis at the clinic was Character-Behavior Disorder. The patient lives with his mother, father, and twenty-six-year-old sister. The patient's father is a person "who doesn't say much". Neither seems to pay much attention to the other. The father seems to be regarded as a rival for the love of the patient's mother who is the dominant member of the household. She has always been very strict with the patient. She will not let him drink or stay out late. Patient accepts this discipline and rather prizes it. Patient's sister had rheumatic heart disease at twelve and had had a severe heart attack three weeks before the patient came to the clinic. She is living at home and is unmarried. Patient has always been shy and found it difficult to get along with people. He did fairly well in school and graduated from the commercial course in high school. He never took part in

extra-curricular activities. After he left school, he went to work as a sales clerk and window decorator.

He was drafted into the Army and worked mostly as a clerk and bookkeeper for "Stars and Stripes". He was in no combat stress. While in the Army he associated with a group of men who "never talked about women". Patient was never hospitalized while in the service but went to the dispensary on two occasions for headaches while in Ireland in 1943. Patient was given an Honorable Discharge as staff sergeant after three years of service.

Patient returned to his former job and then changed to the Veterans Administration Finance Division because he was not making enough money. Just before coming to the clinic he had been laid off his job, as they were cutting down on their personnel. He says that this is the cause for his "nervousness". Patient's home life has been much the same as it was before entering the service. There is a girl who is very fond of him and whom his mother likes, but he does not seem to be drawn to her and wishes she would go away. His mother recently had a breast removed, and this girl has helped by taking care of his mother, but he would rather take care of his mother himself.

When seen at intake this patient seemed to present a picture of overdependence on his mother and latent homosexuality. He was assigned to a social worker for anamnesis,

which was completed in three hours, and was then sent to group therapy. He went to one group meeting and never came back. This patient seemed to want treatment, but group therapy was just too much of a threat to him with his environmental background and personality make-up.

The next abstract is Case Number 5 which stresses the predominant characteristic of the group. It shows a patient who is not ready for treatment and who cannot understand that his illness does not have a physical basis. These patients oftentimes are referred to the clinic from some other Veterans Administration facility because they have a psychoneurotic discharge or because they have been examined, and nothing organically wrong can be found for a somatic effect. The patient refuses to accept that he has nothing physically wrong with him; or his strong superego will not let him believe that he has a "mental" disorder. However, some of the men coming to the clinic with the same attitude do become successful treatment cases. It seems to depend many times on the amount of hostility and aggression and, on the other hand, anxiety in the man and the quality of treatment to push him past the first few appointment hours until a good transference relationship is established.

The amount of anxiety the patient has represents an important guage in the prognosis of treatment. Anxiety may stem from environmental factors as well as psychological. For

example, if a man is able to function fairly well in his situation, that is, is able to work and get along, he is not going to be as anxious for treatment as a patient who is not able to function. This applied to the first case illustration as it does in the next.

This is a thirty-four-year-old married, Catholic, Navy veteran who was referred from OPD to the clinic with headaches and "nervousness". He is receiving a 30 per cent pension for Anxiety Reaction. His provisional diagnosis was Somatization Reaction (immature, aggressive reaction with repressed hostility).

Patient was enuretic until the age of ten. He showed no strong attachment to either father or mother. He had an adopted sister with whom he got along fairly well. Neither she nor patient knew that she was adopted until she finished college. Patient left school at fourteen to go to work and help the family although he really did not have to. He blamed the family for their lack of discipline for allowing him to do this.

He was in combat for ten months while in the Navy. He said he got along well, never had any trouble taking orders from the officers, or worried about regimentation. He first developed headaches while stationed on Manus Island when he was knocked out of a chair following the explosion of an ammunition ship. He was hospitalized four or five months prior

to discharge from the service for headaches, and when he found that his diagnosis was Anxiety Neurosis, he could not understand it as he did not feel worried about anything.

Patient has been married for ten years and has one child. He is working as a carpenter under PL 16.

At intake this man's prognosis was determined as "poor", as he said he could see no reason why he should waste his time coming to the clinic when he did not have a nervous condition. He said that the doctor had sent him here for a nerve check and that was what he wanted. He started treatment with a male social worker. After one interview the worker decided to do an anamnesis because the man was not ready for treatment. When they got to the middle of the anamnesis, the patient said that he had decided not to come back again. To show his ambivalence about coming, the author quotes two parts of the first interview. The first was at the beginning; the other at the end.

> "I have been seen by psychiatrists. I've talked this matter over with my wife. I've gone over everything in my whole life, and I can't see anything at all that would have any bearing on my present condition. I am anxious to get rid of these headaches, but I don't know what good it would do me to come here."

> "But even though I can't see it, the thing is this. You people here know your business and that's why I'm here tonight. And I came because I feel that you people know your business and know what is best. Now if you feel that it will be helpful for me to come here anytime you say, because I really want to get rid of these headaches."

This is what he said just before ending treatment:

"Frankly, I don't see any point in coming here. I don't see how it's going to help me. I've talked it over with my wife."

This man seems to have felt rather rejected by his family as the patient in the first case presented did. Therefore, he had difficulty in relating to the worker. His wife's obvious objection to his being in treatment is possibly another environmental factor.

This was also an important factor leading to failure in treatment in Case Number 22. The patient was also functioning fairly well in spite of the headaches as he was in training to be a carpenter. This, coupled with his ambivalence about treatment and his lack of understanding of it, served to make this man a poor treatment risk. This was the predominant factor in Case Numbers 3, 6, 12, 20, 22, and 23. One of the reasons for this lack of understanding of treatment was given by one of the therapists. He thought that it seemed to be the clinic's threat to the patient's superego.

In summary, the outstanding factor as the reason for unimprovement in this group seems to be ambivalence concerning treatment coupled with a lack of insight into treatment. The underlying environmental factors seem to be rejection in the patient's early background, which has gone into building up a strong superego reaction, and lack of strong environmental stress at the present time that would serve to make the patient

anxious about his condition. By this, the writer means that all of these men had been working but one, and were not in any extreme economic stress. The one that was not working was just waiting for his course to begin in school. In two cases the patients' wives were against treatment; so this was an environmental factor that increased their ambivalence concerning treatment.

TABLE V

REASONS FOR UNIMPROVEMENT

GROUP I

Case No.	Environmental Stress	Reasons for Unimprovement
3	Father died of T.B. when patient 4. T.B. from being gassed in WW I. Rejected by mother and stepfather.	Ambivalent re treatment. Would not trust therapist. No relationship.
5	Rejection by family. Possibility of aggressive wife.	No insight into treatment. Clinic threat to superego.
6	No evident social factors.	No insight into treatment. Hostility toward therapists.
10	Overattachment to mother. Latent homosexual.	Group therapy a threat.
12	Overattachment to mother, who died a year ago.	Patient did not want treatment.
15	Inability to form emotional attachments because of background. Rejected throughout life.	Clinic rejected. Not enough of a relationship established to bring back.
20	No evident social factors. Extreme stress in service.	Ambivalent re treatment. Felt he must come because vocational advisor sent him.
22	Agressive wife who does not believe in treatment.	Does not understand emotional basis for illness. Ambivalent re treatment.
23	In boys' home from age of 2. Never could identify with anyone. Rejected.	Ambivalent re treatment. Could not form relationship with worker.

Group II

Group II, having five to nine contacts with the clinic, represented many of the same characteristics as Group I. None of these men was brought into a strong transference relationship, although they were seen enough times for such a relationship to exist. Several were ambivalent about treatment. Some were assigned to workers to whom they could not relate easily because of their early environmental backgrounds. This group did appear more anxious about their condition than those in the first. The reasons for failure of treatment are listed in the table on the following page.

This is an abstract of Case Number 8. This is a thirty-nine-year-old, married, Catholic veteran. He was referred to the clinic from OPD where he went for stomach trouble. The provisional diagnosis was Neurotic Depressive Reaction characterized by depression, anxiety, nervousness, and irritability. This is all characterized in his symptom of stomach trouble. Prognosis was fair to poor.

Patient has been overly aggressive all of his life. His main enjoyment in childhood was fighting. He left high school because he "pushed the teacher in the waste basket". He took up the drums at sixteen and enjoyed this outlet for his aggressive behavior. He continued playing in an orchestra until he entered the Navy at thirty-six. His main form of recreation was going to fights. His job for fifteen years was as a

TABLE VI

GENERAL CHARACTERISTICS OF GROUP II

No.	Diag-nosis	Age	Home Sit.	Ed. Level	Service Adj.	Service Stress	Marital	Work	Contacts
8	Neur. Dep.	39		10th G.	Poor	Min.	Married	W	6
17	Char. Beh.	20		10th G.	Fair	Min.	Married	W	7
18	Som. Reac.	23	Broken	6th G.	Poor	Med.	Single	Unem.	9
19	Neur. Dep.	29		10th G.	Fair	Med.	Married	W	8
21	Char. Beh.	29		?	Fair	Med.	Married	W	7
24	Obs. Com.	31	Broken	12th G.	Good	Max.	Single	Unem.	8
25	Anx. Reac.	34		8th G.	Poor	Min.	Married	W	6

machine shaver, which calls for force and skill. Patient entered WWII because he had been called a slacker for not going into WWI. He was put into armed guard, although he had requested service as a musician.

Patient's symptoms appeared after he was knocked down by the roll of the ship on his first trip and nearly was washed overboard. Since this accident, he has given a "beaten" appearance. He cannot go back to the drums. In fact, he has sold them. He cannot be a machine shaver because he is too "nervous" to do it. He cannot handle the men in his present job of foreman because he feels he is not sure of himself in the job.

The patient has been married for eighteen years and has two children. The oldest boy is planning to enter the Navy next year. Patient says he has not been getting along with his wife lately because he is so irritable.

This man received three hours of treatment with a psychiatrist and spent three hours on an anamnesis with the social worker. With the social worker he was cooperative and always on time. He told her that he thought treatment was not helping him and did not understand how it could. When seeing the psychiatrist over the same period of time, he was rebellious and hostile and always thirty minutes late. During the first psychiatric interview, he became very upset and suffered a severe anxiety-type reaction. After the first treat-

ment the patient became worse and more irritable at home. Finally he told the therapist that he wished to discontinue treatment and was referred to group, condition unchanged.

The reasons for failure in this case are ambivalence about treatment, hostility toward the therapist, and a failure to relate to the therapist. It is a question as to the basic reason why this man had continually to prove his strength throughout his life. However, we see the pattern throughout the years. Finally he was thrown into a situation where his strength was overcome by fear and something that he could not control. His method for overcoming his basic insecurity was wiped out from under him. In the therapeutic experience he realized that here he was being thrown into another situation that would again threaten his strong superego and weak ego. In relation to this the writer quotes from Grinker and Spiegel:[2]

> "Ego strength, which is so difficult to evaluate, bears a direct relationship to the anxiety which a patient may bear in the process of treatment; weak egos can bear only minute doses of anxiety, so that treatment must be prolonged and often left unfinished. This function of the ego is determined both by the past record and by the current reaction in therapy. The degree of dependence to which the person has become accustomed, the capacity for identification, the plasticity in adaption, and the degree to which he has developed good relationships with others are significant points in progress."

Cases 21, 25, 18, and 19 are all rather similar to this one. None of these men had much insight into treatment and all felt

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2 Roy Grinker & John Spiegel, War Neuroses, pp. 72-73.

rather threatened by treatment.

The next abstract is Case Number 17 on the tables.

This is a twenty-year-old, married, Protestant veteran who came to the clinic complaining of frontal headaches, dizzy spells, loss of appetite and general "nervousness".

Patient is the only male of three siblings. Both parents are alive. He went to tenth grade in school, left to work in the shipyard and then went back to school to finish. Father had a radio business which failed during the depression; so the family was thrown on relief for quite a long period. His father has suffered from asthma since the patient was a child. Patient says both his mother and father are good and kind.

Patient tried to get in the Navy but was rejected because of poor hearing. He was not accepted in the Air Corps because of insufficient education and not accepted by the Army because he had had bronchial asthma in childhood. Finally, he was drafted in April of 1945 and discharged CDD in October 1945. During that time he was hospitalized a month and a half for "nervousness". Patient received a 50 per cent pension.

The patient married a year ago and has one child. Patient is now working as a clerk at the railroad office.

He was seen at the clinic six times, once at intake and five times by a female psychiatric social worker. Each time he was twenty minutes to a half hour late. The interviews were not spontaneous, and he showed a great deal of resistance

to treatment. His diagnosis at intake was Character-Behavior Disorder (passive-dependent).

When seen at intake, he said that his pension had been cut from 50 per cent to 30 per cent which disturbed him greatly. He said that he had been told that he might bolster his claim if he came for treatment. The patient was told that his claim had nothing to do with the clinic so that treatment would not help him in that way. He stated that he would like to come anyway. After seeing the patient three times the worker made the following statement:

> "Worker wonders whether he is coming mainly to prove that he is still ill, knowing that in the event of an appeal the board gets a report from this office. One wonders if the pension money is more important to him than getting well, and if the pension were restored if he would cease coming. On the other hand, there are evidences of anxiety about him."

This case is presented as it represents a very realistic factor in failure of treatment, a desire for a pension adjustment, "pensionitis". The clinic tries to make sure that each patient that is so inclined knows that the clinic has nothing to do with his pensions, but as in any sort of rehabilitation, this can form a definite barrier for success in treatment. As the worker has said in this case, it may be that the man would rather be sick and still get his pension. Again we have lack of anxiety over his illness because he is getting along alright as he is. He is working, and with his pension is able to succeed in a limited manner. In this case there is a

possibility that he has always been sick and doesn't know what it is to be better.

There is another factor that may present itself in this case. The patient is the youngest of three and may have been dominated by his older sisters. There is a possibility of great hostility toward female figures and that may have been the reason he could not relate to this worker.

This group was represented by a total of seven cases. Of these, two were diagnosed as Character-Behavior Disorders, two as Neurotic-Depressive Reaction, one as an Obsessive-Compulsive Reaction, one as an Anxiety Reaction, and one as a Somatic Reaction. Their ages ranged between twenty and thirty-nine. Their education level was between sixth grade and a high school graduate. Five showed hostility, agression, and resistance. Five were married. All were employed but two. Two came from broken homes.

The principal reasons for failure in treatment were much the same as in the last group. Six of these patients had little insight into treatment. Three could not relate to the therapist. Four seemed to be threatened by treatment.

This is a heterogeneous group. The one general environmental factor which seems to apply is that all had some figure in their lives to whom they showed tremendous aggression and hostility which became projected onto treatment. The chief difference from Group I seems to be in amount of anxiety.

This group did show some anxiety; whereas Group I showed very little.

TABLE VII

REASONS FOR UNIMPROVEMENT

GROUP II

Case No.	Environmental Factors	Treatment Factors
8	Need to prove masculinity all life by show of aggression. Weak ego, strong superego	Could not get into relationship with male therapist. Ambivalent re treatment.
18	Rejection pattern. Low intelligence. Hated by father because of size. Wanted to kill father. Overattached to mother.	Little insight into therapy. Threatened by treatment.
19	Borderline intelligence. Psychotic epis. in service. Marital problem.	Did not want to be reminded of episode in service. Little insight into treatment.
21	Overattachment to parents. Sibling rivalty. Excessive compulsive traits.	Little insight into treatment. Too much interpretation for weak ego too soon.
24	Overattachment to mother. Conflict of whether to marry. Father died at 10 months. No male to identify with.	No insight into treatment. Relationship not strong enough to hold.
25	Possible marital conflict. Low intelligence.	Little insight into treatment. Threatened by others in group. Desire for raise in pension.
17	Three older sisters. Hostility toward female figures.	Desire for raise in pension. Could not relate well to female social worker. Ambivalent re treatment.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA (CONTINUED)

Introduction

Groups III and IV are to be presented in this chapter. In all of these cases there has been a transference relationship established; but because of various reasons stemming from the patient's background, present environmental situation, and psychological makeup, this transference has not held. All of these patients were convinced that they did need psychiatric treatment. Therefore, the reasons for failure in treatment are much different from those in Groups I and II.

Group III

Group III consists of those patients who had from ten to fourteen contacts with the clinic. It consists of only three cases. All three showed a great deal of anxiety about their condition. Two represented a high degree of educational achievement, and the other had had the least education in the total group. All three were single and among the youngest in the total group. One was a student, and the other two were working. Two were diagnosed as Anxiety Reaction, and the other had the diagnosis of Character-Behavior Disorder. Two came from broken homes. Two told the therapist that they did not wish to continue treatment, and the other just ceased

keeping appointments. The table listing the general characteristics will be found below.

TABLE VIII

GENERAL CHARACTERISTICS OF GROUP III

No.	Diagnosis	Age	Home Sit.	Ed. Level	Service Adj.	Service Stress	Marital	Work	Contacts
4	Anx. Reac.	20		12th G.	Good	Med.	Single	W	14
13	Anx. Reac.	26	Broken	6th G.	Good	Max.	Single	W	12
14	Char. Beh.	21	Broken	12th G.	Bad	Min.	Single	Stud.	13

The following is an abstract of Case Number 14:

This is a twenty-one-year-old single veteran who was referred by a friend at the college he is attending.

Patient was in the service for three years and was given a medical discharge for exzema. He receives a 30 per cent pension. He was hospitalized for three months and given some psychiatric treatment.

Patient lives at home with his mother and three sisters. His father has been in a state hospital for fifteen years with "Dementia Praecox". Patient's father had his first psychotic breakdown when he was coming back from overseas in WWI. Last December was the first time the patient had ever visited his father, and it made him very upset. He feels he is not

doing very well in school because he is so "mixed up". He is afraid he will lose his mind and become like his father.

At intake he was diagnosed as a Character-Behavior Disorder, Schizoid Personality. He was assigned to a woman psychiatrist. The patient resented being treated by a woman. ("I resent being bossed around by any woman.") He had a great deal of hostility directed toward woman figures, especially his mother and sisters. He blamed his mother for his father's illness. Because of his great need to have a father figure, it is unfortunate that he was assigned to a woman. However, there was some relationship established, but because of his resentment toward women it was very difficult to break down his resistance.

There is also the question of how much success psychotherapy could have in a case like this. There is the heredity factor that seems to have strong bearing on the character predisposition of this man.

TABLE IX

REASONS FOR UNIMPROVEMENT

GROUP III

Case No.	Environmental Factors	Treatment Factors
4	Oldest of four boys - rivalry. Aggression all life.	Resistance. Intellectual curiosity re treatment, not all anxiety. Function not impaired.
12	Ambivalence toward mother & sister. Father in mental hospital. Hereditary disposition. Need of male figure to identify.	Could not relate to woman therapist. Character disposition.
13	Low intelligence. Misformed lip over which he is self-conscious.	Hostile and suspicious of therapist. Low intelligence. Difficulty in relating.

Group IV

Group IV is perhaps the most interesting from a study point of view, as each man had gone through a great number of treatment hours, had a transference relationship with the therapist, and really wanted to be helped, but something kept him from improving. The reasons for failure are listed in Table XI and will be discussed later. The writer will present three abstracts from these six cases that had fifteen or more contacts with the clinic. The following is an abstract of Case 1:

This is a twenty-seven-year-old patient who was referred from the NP Unit of OPD. He complains of lack of appetite, restlessness in sleep, occasional dreams of combat experience, and irritability. The provisional diagnosis was Neurotic Depressive Reaction. Prognosis not given.

Patient was the middle of three boy siblings. He does not remember his father well, as he died in 1929. He describes his mother as "neurotic" and "better dead". Patient says mother blames him for her partial invalidism and never showed any affection. All of the children were treated like investments. Patient was father's favorite until he died. The family got along as best they could with the help of widow's aid after the death of the father. Patient attended a state college and majored in hotel stewarding. As he was graduating from college, his older brother was killed in

action, and he immediately asked for his graduation certificate and enlisted. Patient greatly admired his older brother and blamed mother for brother's death, as he said that she had nagged him into joining the Navy. While in college, the patient supported himself, receiving no help from his family. He resented the fact that they did not help him.

TABLE X

GENERAL CHARACTERISTICS OF GROUP IV

No.	Diag-nosis	Age	Home Sit.	Ed. Level	Service Adj.	Service Stress	Marital	Work	Contacts
1	Neur. Dep.	27	Broken	College	Good	Max.	Married	W	24
2	Char. Beh.	26		12th G.	Good	Max.	Single	Stu.	18
7	Neur. Dep.	21	Broken	9th G.	Good	Max.	Single	Unem.	21
9	Diss. Reac.	24	Broken	9th G.	Fair	Max.	Single	Stu.	18
11	Char. Beh.	25		10th G.	Fair	Min.	Married	W	21
16	Char. Beh.	29		Grade School	Good	Max.	Single	Stu.	20

In 1937 patient had an operation for neurological condition. The medulla was forced into the cranium magnum. His symptoms at the time were severe headaches, dizzy spells, inability to swallow, and a feeling of great depression. The operation was succcessful, and there has not been a reoccurrence

of these symptoms.

The patient saw eighteen months of combat as a second lieutenant in the combat engineers. He was reconnaissance officer and had a dangerous job. He was called "blood and guts" by his men. His feeling was that his job was not recognized as as difficult as it really was. He did not get along well with the other officers, as he did not like to "apple polish". He was discharged on points in 1946.

Patient was married in 1943 to a girl he had known all of his life and of whom he is very fond. There are two children, a boy three, and a girl eight months.

Patient has had three jobs since returning from service. He has rebelled against the authority imposed in each one of them. He still has a great deal of hostility against his mother and finds himself reacting in the same way against his children. This inability to get along in a work situation is seemingly service connected, as he had made a good work adjustment before the service.

This patient has received intensive treatment at the clinic for a period of six months. He has been seen twice and sometimes three times a week. He was discontinued for two months while his claim was being adjudicated. He is still unimproved in symptoms although he is holding a job and seems to be getting along well in it. The main source of his trouble seems still to be a basic dependency interwoven with

hostility toward women figures. The patient has been receiving treatment from a woman psychiatrist while his wife has been helped by a social worker. Patient felt that his wife was not a good housekeeper, as she is not neat and wastes food and money. The aim of her appointments with the social worker was to receive help on budgeting. Finally, the patient had to discontinue treatment because he was away a great deal of the time and could not get into the clinic regularly.

This man has had a series of rejections, first by his father, then his mother, and them his brother. Finally, in the Army he was "rejected" again when he did a dangerous job and did not receive all of the recognition that he should have for it. He reacts with hostility, aggression and lack of trust in all contacts, especially with women, as these have proven to be the most traumatic for him. Therefore we see the difficulty there is in establishing a "trusting relationship" with this man especially when the psychiatrist is a woman. Although he intellectually realizes that he needs treatment, he unconsciously resists it. This case seems to be similar to Case 14 in Group III.

The next is an abstract of Case 2. This patient first went to the neuropsychiatric section of OPD, from where he was referred to the Mental Hygiene Clinic. He complained of being restless, irritable, frustrated, and of having stomach trouble. He also continually worried that he might not be

normal and thought people did not like him. He felt extremely out of place all of the time.

The patient's background gave this sort of picture. He had one brother two years younger than he for whom he had been given a great deal of responsibility. His father was a chronic alcoholic. He started drinking heavily in 1929 and had not given the family enough economic support to keep them at the social level (lower middle class) at which they had been formerly living. This caused friction between his parents and many hardships for all of them. The patient identified with his father and "felt sorry for him" rather than blaming him. He was ambivalent toward his mother. He finished high school and took two years of accounting before entering the service. His early history shows a tendency toward "nervousness". He stuttered excessively until he was ten. He felt shy until twelve years old. Patient almost did not pass draftee exam because the doctor noticed his excessive perspiration.

Patient did not show any nervous symptoms in the service. He was drafted in 1942 and was made an aviation cadet. He washed out of flight school when he crashed a plane in which he would have been killed if it had not been for good flying and quick thinking. He was considered one of the men with the greatest potentialities in flying. He was sent to bombardier school and commissioned from there. He was sent overseas and

after flying two missions was shot down and taken prisoner of war. He did not mind this life at all and only worried occasionally about not getting food. When an aviation cadet, he disliked officers and when an officer, he disliked higher officers. He was always anxious to be on good terms with the enlisted men and sometimes acted as their champion.

After leaving the service in 1946, he took several jobs and felt that all of them were beneath him. He tried to organize a union in one place and was fired. The patient is now twenty-six. He has just broken up with a girl with whom he has been going for several years. The girl is Jewish, and her family did not want her to marry someone who is not of her faith. The patient is Protestant. The patient is going to college and doing fairly well there. He lives at home with his father, brother, and mother.

The patient's stomach started bothering him when he was at the prisoner of war camp in Germany. His symptoms have grown continually worse since leaving the service. At intake he was diagnosed as Anxiety Reaction. It was thought that the prognosis was good. Patient's relationship with a male social worker was good during the taking of the anamnesis. Patient resented the psychiatrist whom he saw after the social worker and complained that the social worker guided him by questions and the psychiatrist expected him to talk without being guided. He kept several appointments, but did not really

accept the therapist. Finally he was discharged, condition unchanged. The diagnosis at discharge was Passive-Aggressive Reaction.

This man showed resistance, hostility, and aggression during the process of treatment. This brings out two very interesting factors in regard to treatment: 1. This patient was very successful in the Army where he was told what to do; whereas, he has had a difficult time at home where he was given too much responsibility at an early age. 2. He enjoyed the case-work relationship where he was guided and more or less "protected". He felt threatened by the contacts with the therapist because he was not guided. This case rather points out the type of person with whom supportive case work can be of value. Probably if this case had been diagnosed "Passive-Aggressive" in the beginning, it would have been given to a case worker, as the clinic has already observed this fact. The reason for this Passive-Aggressive disorder would probably lie in this man's identification with his father, a weak individual, and his conflict not to be like him.

Number 7 is the case of a twenty-one-year-old, single, Catholic patient who lost a leg in WWII. His provisional diagnosis was Neurotic-Depressive Reaction. He complained of vomiting daily, particularly before and after putting his leg on. He also had a pain in his heart many times, and his back felt tightened.

During the twenty-one interviews the patient had with the psychiatrist, he brought in the following background information. Patient was the oldest of three brothers. Eight other siblings had died during infancy. When he was twelve, his father "took off" and deserted the family. Patient's father was a carpenter and a taxi driver. He had been brought up in a tough neighborhood where the children were taught to fight for everything they got. During childhood he had pneumonia eight times and had an attack of rheumatic heart. He was very proud of the fact that this had never bothered him, as he had always been very athletic and strong. He got very good marks during grammer school and was given a chance for a double promotion three times. His marks fell down when he entered high school because of the stress in the family after his father left. He entered the Marines at seventeen. He saw severe combat stress in the service and lost his leg. Since returning he has been living with his mother and one brother. The other brother is in the Navy. Patient is not working but is collecting unemployment compensation and his pension of $118 which he gives to his mother.

Patient shows a great deal of ambivalence toward his father. During interviews he would praise his father's great physical strength and other things, and then say that he would not even admit he had a father because of the terrible things he had done. He is very attached to his mother. One of his

conflicts lay in trying to decide whether he should break away from the love for his mother, or whether he should be passive and stay. He decided on the latter. There was also a great deal of sibling rivalry which was exposed in the interviews.

The therapist described the patient as having "a usual air of self-assured condescension". In practically every interview he showed a very aggressive and hostile attitude and was often hostile toward the therapist. By the third interview, the doctor noticed "a peculiar mixture of desire and need for sympathy and understanding together with a very aggressive, almost hostile, pushing forward and expanding his own ego". By the sixth interview he became very aggressive toward the therapist saying, "I have a right to punch a guy in the nose if I want to". By the seventh interview it was evident that the patient resisted "every attempt to find meanings in what he says or to tie them together in any sort of uniform pattern". In the eighth interview he continued to resist interpretation. In the twelfth interview he told the therapist that he resented interpretation. By the eighteenth interview, he still resisted the interpretations but did it in a "more friendly way". From the eighteenth interview on, we notice an increased number of broken appointments. Finally, after the twenty-first interview, he ceased coming for good. In the final summary the therapist brought out the following points:

1. Patient is unwilling to break away from mother.

He cannot fall in love with anyone else.

2. Patient has accepted the role of dependence (on mother).

3. Patient will not give up acts to prove masculinity.

4. Patient seems improved to the therapist because he at least has resolved his conflict, but since the patient does not feel he is improved, he is discharged "unimproved".

This case clearly shows a conflict in identifications. When the patient finally resolved his conflict and decided to stay with his mother, he left the therapist or the father figure. However, in another way he still does have his conflict, as he is still trying to prove his masculinity. This case is included to point out the difficulty in saying whether such a case is "improved" or "unimproved". If this man would admit that this was the way he wanted to be, this case would definitely show improvement.

TABLE XI

REASONS FOR UNIMPROVEMENT

GROUP IV

Case No.	Environmental Factors	Treatment Factors
1	Hostility toward mother and female figures. Rejected by father because of his death. Rejected by brother by death.	Resisted woman therapist.
2	Identification with but rejected by father. Given too much responsibility in childhood. Wants to be dependent and protected.	Felt threatened by psychiatric treatment. Supportive treatment may have worked better.
7	Overattachment to mother. Rivalry and finally rejection by father. Ambivalence toward father.	Conflict as to identifying with mother or therapist in father role.
9	Hostility toward mother. Broken home.	Resistance to treatment.
11	Hostility toward sibling. Poor economic status.	Strong superego reaction which made it difficult for him to accept dependent needs.
16	Secluded childhood. Homosexual tendencies.	Conflict between latent and overt homosexuality. Seems to have lost anxiety about it while in treatment.

It is interesting to note that this group especially has been able to adjust or get along quite well up until the present. This group has the highest education level of the four groups. Five out of six saw maximum service stress and four of these made a good service adjustment while the other two made a fair one. It is also interesting to see that only two out of the nine represented in Groups III and IV were married and had the stress of supporting a family. However, most of these single men were in a conflict situation such as whether to stay at home or leave. Although this may not have been the chief difficulty, it represented a great stress. The mere fact that these men that had this conflict did break away from treatment after so many contacts seems to show that treatment was not all in vain. It does show an increased ego strength in being able to break away from a protecting situation.

In these last two groups the men's conflicts seem to have represented more to them than in the first two showing an increased amount of anxiety about themselves. It would bear out that if these latter two groups had succeeded fairly well in their environmental situations as they seem to have done, the stress of indecision and symptoms would seem greater to them. Therefore, it would seem that they would have more desire for treatment and so stay in treatment longer.

CHAPTER V

SUMMARY AND CONCLUSIONS

From the material presented by these four groups arranged by number of contacts, we may come to the conclusions that some of these men want treatment more than others. This seems to depend, first, on their understanding of their illness and whether they really want treatment, and secondly, on the stress that is put upon them at the time from the environment. If they have a family to support and cannot work because of their symptoms, they will naturally be more willing to accept treatment than someone who is carrying on in spite of his symptoms, and really want to cooperate to help themselves. The last factor is dependent on the level they have previously been able to achieve. A man who had made a fairly good adjustment to his environment will want to get back to that level if he has regressed, more than one who has never attained it. All of this material brought out from the number of contacts the man had with the clinic seems to form one phase in the question of whether a case is successful or unsuccessful. It is desire for treatment. In Grinker and Spiegel's criteria for prognosis, it would represent:

1. Patient's predisposing liabilities.
5. Quantity of anxiety
7. Capacity for psychological understanding.

10. Time element.[1]

The other element in treatability that seems to present itself in this study represents itself in the personality makeup of the individual. Those that seem to be resistive, hostile, and aggressive seem harder to treat than others. If the cases used in this study are any evidence for the reasons for this disposition, it seems that those people who have had lives that are full of rejection and rivalry situations are more difficult to treat successfully than others because of the resistance it seems to build up in them. These two factors then present themselves: 1. The desire for treatment stemming from present environmental stress and level of achievement in the past. 2. The predisposition for treatment in the patient which is affected by previous environmental situations mainly of a rejection-rivalry nature.

Although statistics coming from this study are not valid because of the small number of cases used, it is interesting to make a comparison with the study on successful cases.[2] Approximately two-fifths of the successful cases were not employed. One-sixth of the unsuccessful cases were not employed. None of the unsuccessful cases showed any great discontent at their employment; whereas, more than half of the successful cases were dissatisfied. Both groups seemed to be

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1 Roy R. Grinker and John P. Spiegel, War Neurosis, p. 71.

2 Park, op. cit., pp 149-151.

of average intelligence. About half of each group was married. Both groups had a large number of siblings. One-fifth of the successful cases came from broken homes, and nearly one-half of the unsuccessful cases came from broken homes. This last seems to be most significant. Even though the statistics are not valid, it bears out this pattern of rejection and rivalry that so often arises from the broken home situation, and which seems to be represented in so many of these unsuccessful patients.

The writer quotes Mrs. Park's conclusions in which she makes some possible predictions for a study on unsuccessful cases:

> "While it is not safe to assert that any aspects of environment of patients successfully treated by the clinic promises to yield a basis for differential predictions of success of treatment of future Mental Hygiene Clinic patients, it does seem warranted to indicate briefly those areas in the lives of patients which look to have the best chance of yielding such a basis for prediction. In general, in areas of relationship to siblings, socialization, heterosexual adjustment, occupation, fulfillment of economic responsibility, education, law abidingness, and health (until current symptoms), these patients portend to stand relatively high in comparison with their unsuccessfully treated fellow patients. While it is possible that educational achievement may answer to relatively high intelligence in these patients, this does not alter the fact that educational achievement of the patients may bear any striking relationship to successful treatment. Similarly, striking relationships may be discovered between the high number of siblings and the good health of the patients before onset of symptoms which brought them to the clinic on the one hand and success of treatment on the other hand. However, it must be remembered that no one of the areas can be assumed to have yielded any more significant results than any other area or combination of areas until comparable data about

unsuccessfully treated veterans are available."[3]

As pointed out before, the one area that seems to stand out as an environmental difference in the two studies is centered around the home constellation. A great many of these men who have been unsuccessful in treatment come from broken homes. If the home is not broken, there is some other striking difficulty such as a very weak father figure, or a very dominant mother figure, or great rivalry among the siblings. In the other areas of socialization, heterosexual adjustment, education, law abidingness, and health, and high number of siblings there are not striking differences between the successful and unsuccessful patients. The only difference in the area of "good health" that could be pointed out would be the fact that a much greater ratio of the unsuccessful patients was diagnosed as Character-Behavior Disorders indicating that they had a predisposition toward psychoneurotic illness and had been "ill" in a way for some time.

In conclusion, the answers to the questions formed at the beginning of this study would seem to be as follows:

1. There does seem to be a personality type that resists treatment. At least a large number of the patients used in this study showed great hostility, resistance, and aggression in not being able to take interpretation or being able to identify with the therapist. Also the large number of

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[3] Park, op. cit., pp 150-151.

Character-Behavior Disorders represented seems to indicate that those men falling into these personality disorders would be more difficult to treat.

2. Factors in the patient's background that seem to be related to this personality picture are in many cases connected with broken homes in which rivalry and rejection situations are built up, or, where there is a bad sibling rivalry situation, or, as in some cases where there is a very dominant mother figure and a weak father figure in the home. In general, in most of these patients' backgrounds there seems to have been some situation that has built up a great deal of resistance in the personality.

3. This study does not seem to suggest any particularly significant ways failure in treatment may be overcome. The clinic is aware that Character-Behavior Disorders do not seem to benefit perceptively from psychiatric treatment, and for this reason a great many of these patients are now assigned to social workers for supportive case work. One of the difficulties that seems to show itself is the assignment of a patient with a great deal of hostility toward a woman figure to a woman therapist or visa versa. In several of these cases it seems to have hindered treatment. It is possible that more care should be taken in the assignment of cases. This study also suggests that a more careful investigation into reasons for referral and reasons for coming to the clinic at intake

would save in treatment hours by the weeding out of men with little anxiety about their symptoms and who have mostly a desire to prove that they are sick and little desire to get well. This study would also seem to indicate that those men who do not have a great amount of pressing environmental stress do not have any great desire to respond to treatment, and therefore, may not respond to treatment.

Approved,

Richard K. Conant

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APPENDIX

APPENDIX A

ANAMNESIS

NAME: CLAIM NUMBER CASE NO.

RESIDENCE: RANK & ORGANIZATION:

TELEPHONE NUMBER: RACE:

MARITAL STATUS: RELIGION:

AGE: BIRTHDATE: DATE OF REFERRAL:

I. Informant: Patient, or other.

II. Method of referral: Self-referred? If not, sent by whom? Quote reason for referral, if supplied by referring agency. Include patient's statement also, and whether he understood reason for referral.

Date of First Consultation with Social Worker:

III. First Mental Symptoms:

A. Chronological account of onset and development of symptoms:

Present Symptoms: - pains, (head, heart, etc.) rapid heart beat? Trouble breathing? Constipation? Others?

Previous History of Symptoms: - previous treatment or hospitalization? Civilian or military - dates - duration, treatment or hospitalization during military service - dates, etc. On sick call frequently? Main reason for going?

Degree to which Incapacitated at Present: - Able to work?

B. Mental Status:

Habits - excessive smoking or drinking, drugs, gambling, other.

Recreation - solitary? Passive? Hobbies? Same as when civilian?

APPENDIX A (Cont.)

Stammer, stutter, obsessive or compulsive traits, day-dreaming.

Dreams, nightmares, sleep-walking or talking, grinding of teeth.

Phobias - drak, crowds, lightning, high places, closed or open spaces, death, water, blood, snakes, other.

Mood - happy, sad, disgusted, tired, hopeless, lonely, indifferent, idea of suicide?

Odd experiences - voices, visions, feelings of unreality, nihilism, persecution, grandiosity?

IV. Family History:

A. Parental Background: - Nationality of grandparents, occupation and economic status. If patient lived with any grandparent in early life, describe that grandparent in detail. Any unusual diseases in family, such as: epilepsy, T.B., cancer, insanity, excessive drinking, etc?

B. Parents: - Describe in separate paragraphs. Include age, nationality, educational background, occupation, state of health, type of person, disposition. Relationships between patient and parents, normally affectionate? Did patient feel neglected?

C. Siblings: - List in order, and describe, including attitude toward patient.

V. Previous Personal History:

A. Infancy: - Any information regarding condition at birth, whether breast-fed. Any training difficulties? Tantrums, crying, weaning, eating, sleeping. Habits, enuresis beyond 4 years? Thumb-sucking or nailbiting beyond 6?

B. Diseases: - Healthy or sickly as a child? Usual childhood diseases? Operations, accidents, nervous breakdowns, fits, etc. Time missed from school because of health?

C. Development: - Home background during early years, economics, etc. Quarreling, discipline. Patient closest to whom? Any running away? Description of patient and his early behavior, relative size for age, solitary or social,

APPENDIX A (Cont.)

bashful or shy, leader or follower in his group? Many fights? Attitude toward parental discipline. Deaths or other great shocks?

D. School Record: - Age and grade begun, completed, years held back, why quit? Attitude toward school, teachers, etc. Behavior, grades, participated in school activities?

VI. Work, Religion, Legal & Sex Records:

A. Work Record: - Until induction. Chronological account of jobs held, type of work. Adequate pay? Length of time, success, relations to employers and fellow workers. Work ambitions.

B. Religion: - Creed, attendance, activities, real or nominal interest.

C. Legal Record: - Ever arrested? On what charges? Disposition. Ever injure others, even accidentally?

D. Sex Record: - Age of puberty, when voice changed, etc. Did patient have any emotional problems at that time? Any sex information? Age when first interested in girls. First dates. Number of love affairs, success, married happily, or unhappily? Description of wife. If single, why?

VII. Service Record:

A. Military Record: - Also experiences in Service. Date and place of induction or enlistment; if enlisted, reason. Basic training where? Chronological account of places stationed, duties, schools, camps, promotions, plans, expectations. Relations to fellow soldiers, noncoms and officers. Accepted in the group? Discipline, often AWOL, Company punishment? Stress, what bothered patient most about military life. Attitude toward Army, hostile? Wasting time? Traumatic experiences, battle experiences, wound of self, death or injury to buddies? Date of discharge, type, circumstances surrounding it.

APPENDIX A (Cont.)

VIII. Readjustment to Civilian Life:

A. Full account of how patient returned home; disappointed, or satisfied with home conditions he found? Any changes in mood, manner of speech, attitude toward others, and ability to adapt to civilian life? Work history since discharge, efficiency. Reasons for changing positions? Present economic status and social situation. Living on pension? Does he want pension increased? Attitude toward pension?

IX. Summary:

A. General description of body build, manner, personality, etc. Shy? Reserved? Out-spoken? Speaks spontaneously, or with hesitation?

Short review of when symptoms began and circumstances surrounding it, and chronological account of how they developed, and what treatment was given.

Select from history sensitive spots and formulate pertinent traumatic events and conflictual areas. How are these related to present environmental situations?

Social worker's impression as to what the patient needs. Include opinion of patient's awareness of his illness, insight into the need for treatment and his urgency for treatment.

Social worker's recommendation: Does patient need psychiatric treatment? Are there environmental factors which should also be taken care of? Do related problems in present situation need attention of some other agency? (Example: wife need treatment?)

APPENDIX B

TABLE OF EQUIVALENTS
PSYCHIATRIC NOMENCLATURE

New VA Nomenclature	AMA Standard Nomenclature
I. TRANSIENT PERSONALITY REACTIONS	
A. Acute Situational Maladjustment	(Simple Adult Maladjustment)
II. PSYCHONEUROTIC DISORDERS	
A. Anxiety Reaction	(Anxiety State)
B. Dissociative Reaction	(Conversion Hysteria, amnesic type)
C. Phobic Reaction	(Phobia)
D. Conversion Reaction	(Conversion hysteria)
Anesthetic type	(Conversion hysteria, anesthetic type)
Paralytic type	(Conversion hysteria, paralytic type)
Hyperkinetic type	(Conversion hysteria, hyperkinetic type)
Paresthetic type	(Conversion hysteria, Paresthetic type)
Autonomic type	(Conversion hysteria, autonomic type)
Mixed type	(Conversion hysteria, mixed hysterical psychoneurosis)
E. Somatization Reactions	
1. Psychogenic gastro-intestinal reaction,	

APPENDIX B (Cont.)

New VA Nomenclature	AMA Standard Nomenclature
Stomach (Specify manifestations)	(Diseases of stomach due to disturbance of innervation or of psychic control)
Small intestine (Specify manifestations)	(Diseases of intestine due to disturbance of innervation or of psychic control)
Large intestine (Specify manifestations, e.g.)	(Diseases Due to Disturbance of innervation or of psychic control)
Irritability	(Irritability of colon)
Atony	(Atony of colon)
Mucous Colitis	(Mucous Colitis)
Rectal Neurosis	(Rectal Neurosis)
Anorexia Nervosa	(Anorexia Nervosa)
2. Psychogenic cardiovascular reaction (Specify manifestations)	(Neurocirculatory Asthenia)
3. Psychogenic genitourinary reaction (Specify manifestations)	(Psychogenic sexual impotence)
4. Psychogenic respiratory reaction (Specify manifestations)	(Bronchial spasm, due to disturbance of psychic control)
5. Psychogenic skin reaction (Specify manifestations)	
Angioneurotic edema	(Angioneurotic edema)
Neurotic excoriations	(Neurotic excoriations)

APPENDIX B (Cont.)

New VA Nomenclature	AMA Standard Nomenclature
E. Somatization Reactions (cont.)	
Anhidrosis, etc.	(Anhidrosis) etc.
6. Psychogenic reaction, other (Specify type and manifestations)	
F. Asthenic Reaction	(Neurasthenia)
G. Obsessive-Compulsive Reaction (Specify Manifestations)	(Obsession)
	(Compulsive tics and spasms)
	(Mixed compulsive states)
H. Hypochondriacal Reaction	(Hypochondriasis)
I. Depressive Reaction	(Reactive depression)
III. CHARACTER AND BEHAVIOR DISORDERS	
A. Pathological Personality types	
1. Schizoid personality	(Psychopathic personality with pathologic emotionality) (Schizoid personality)
2. Paranoid personality	(Psychopathic personality with pathologic emotionality) (Paranoid personality)
3. Cyclothymic personality	(Psychopathic personality with pathologic emotionality) (Cyclothymic personality)
4. Inadequate personality	(Psychopathic personality, mixed types)
5. Antisocial personality	(Psychopathic personality with asocial or amoral trends) (Antisocialism)

APPENDIX B (Cont.)

New VA Nomenclature	AMA Standard Nomenclature
A. Pathological Personality types (cont.)	
6. Sexual deviate	(Psychopathic personality with pathologic sexuality)
B. Immaturity Reactions	
1. Emotional instability reaction	(Psychopathic personality with pathologic emotionality) (Emotional instability)
2. Passive dependence reaction	(Conduct disturbance)
3. Passive aggressive reaction	(Conduct disturbance)
4. Agressive reaction	(Conduct disturbance)
5. Immaturity with symptomatic "habit" reaction	(Habit disturbance)